DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

March 16, 1993

REASON FOR THIS TRANSMITTAL
[X] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[ ] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

ALL-COUNTY LETTER NO. 93-21

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: PERSONAL CARE SERVICE PROGRAM IMPLEMENTATION

REFERENCE: ACIN I-66-92

The California Department of Social Services (CDSS) and Department of Health Services (DHS) are scheduled to file emergency regulations prior to April 1, 1993 to implement the Personal Care Services Program (PCSP) portion of In-Home Supportive Services (IHSS). Pertinent portions of DHS' regulations have been incorporated as handbook within the IHSS regulations for easy reference by county staff.

The purpose of this letter is to transmit an advance copy of the PCSP regulations (Attachment A). In addition, this letter transmits copies of four state mandated PCSP forms. Finally, this letter highlights new PCSP policies and how they differ from those outlined in the ACIN I-66-92 dated December 10, 1992.

SB 485 and AB 1773 linked the restoration of hours reduced October 1, 1992 to the implementation of PCSP. Therefore, on implementation, all IHSS recipients whose hours were reduced pursuant to SB 485 (the 12% reductions), will have their hours restored. This process will occur automatically. The only county involvement required will be the filing of copies of Notices of Action (NOAs) and turn around documents (TADs).

TERMINOLOGY

In December 1992, we were calling the Medicaid (Medi-Cal) funding of IHSS "Personal Care Option (PCO)." We now call that portion of the IHSS Program "Personal Care Services Program (PCSP)." As used in this ACL and in the regulations, IHSS refers to the overall program; PCSP refers to the Medicaid-funded portion and non-PCSP refers to the residual portion of IHSS which does not qualify for Medicaid funding.

IMPLEMENTATION

Statewide implementation of PCSP is scheduled to begin April 1, 1993. The Case Management Information and Payrolling System (CMIPS) will assist in the implementation process as much as possible. Automation of the case information tracking and billing will occur with implementation of PCSP. CMIPS-specific information about transition and implementation will be described in detail in a separate ACL.

PCSP ELIGIBILITY

As stated in ACIN I-66-92, PCSP recipients must be categorically eligible for Medi-Cal as cash assistance recipients. IHSS income eligibles will not be eligible for PCSP but will continue to be served by non-PCSP as long as they continue to meet the basic IHSS income eligibility requirements.

An additional PCSP eligibility requirement is that the individual must have a chronic, disabling condition that causes functional impairment which is

expected to last at least 12 months or result in death within 12 months and that disability affects the individual's functioning such that he/she is unable to remain safely at home without IHSS/PCSP. Any individual who has received IHSS for the past 12 consecutive months meets this criteria. Any individual who receives SSI/SSP based upon disability also meets this criteria as does any person who is expected to require IHSS for a total of 12 months or longer.

In making the determination of 12 month disability, the county shall consider whether the applicant has been determined eligible for SSI/SSP due to his/her disability. Disabled PCSP applicants who have not been determined to be SSI/SSP eligible shall be referred to that program for determination of their eligibility. For persons whose SSI/SSP linkage is that they are over 65 years of age, counties are required to verify diagnosis and prognosis for the 12 month portion of the determination and to conclude that the recipient meets severity criteria by ranking at least a "3" in one mental or personal care function using the Uniformity System.

This determination of disability is required at intake. Any individual who fails to meet the disability criteria but who otherwise meets all IHSS eligibility criteria is eligible for non-PCSP services.

NEED

Recipients eligible for PCSP will be those who require one or more personal care tasks listed in MPP 30-757.14 (HH through RR on the SOC 293), protective supervision (WW on SOC 293) or paramedical services (YY on SOC 293). If the recipient qualifies for PCSP funding, all personal care tasks, protective supervision, paramedical services and "ancillary services" are subject to PCSP funding. "Ancillary services" are all other IHSS tasks. However, if a PCSP recipient opts for restaurant meal allowance in lieu of meal preparation and shopping (ZZ6), tasks provided will be funded by PCSP but the restaurant meal allowance will be funded from non-PCSP funds.

PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY

At county option, during the week of February 22, 1993, CDSS generated a letter and a form to IHSS recipients who are potentially eligible for PCSP. The letter describes PCSP to recipients (Attachment B). The completed form, SOC 425 (Attachment C) is to be filed in the recipient's case record. The SOC 425 is considered to be complete if, at a minimum, it is signed and the physician's name, address and phone number are on the form, and the physician checks the block which states that the physician recommends one or more of the personal care services in order to prevent out-of-home placement.

During this transition period, if the recipient's case record contains a medical report which is less than 12 months old and which contains a diagnosis, prognosis and a recommendation for personal care services, this form can be used in lieu of the SOC 425 as long as the county is providing exactly what the physician has specified on the form.

Physician recertification must be completed annually.

ADVANCE PAY RECIPIENTS

Severely impaired recipients continue to be eligible for the option of advance payment. However, if the recipient opts for advance payment, even if he/she meets all other aspects of PCSP eligibility, his/her care will continue to be funded by non-PCSP funds. This is because there is a federal prohibition on paying Medicaid funds directly to a beneficiary or paying for services before they are rendered.

SERVICE DELIVERY MODES

No changes will be made to mode choices available to counties as a result of the implementation of PCSP. Counties will continue to have the option of providing IHSS/PCSP through any of the specified modes as long as the cost of the mode selection does not increase the cost of the program in the county. If a county takes action to either increase the proportion of IHSS/PCSP hours served by a more expensive mode or increases the rate per hour without state approval, the increased cost will not be eligible for state matching funds.

Although the county employee mode continues to be an option to counties, we will not be able to fund services provided by the county employee homemaker mode from PCSP in the immediate future. Counties which use that mode will be notified when a tracking system has been developed to capture county homemaker service hours.

PROVIDER ENROLLMENT

Providers must be enrolled as Medi-Cal providers to be eligible for PCSP funding. This is accomplished for individual providers (IPs) by signing the required provider enrollment form SOC Temp B (1/93) or SOC 426 (Attachment E). PCSP funding may not be used for any provider before that provider has been enrolled as a Medi-Cal provider. Enrollment has occurred once the fully completed provider enrollment form has been signed by both the provider and the recipient and is in the possession of the county and the information is **entered into CMIPS** via the PCSP eligibility summary (SOC 428). If the county receives the completed form in the middle of a pay period, PCSP funding can begin for that provider for timesheets submitted after the SOC 428 is processed.

If the recipient is unable to sign the form because of mental impairment, an authorized representative must sign on behalf of the recipient. However, the authorized representative may not also be the provider, even if the provider is the individual delegated to act on behalf of the recipient in legal matters. At county option, the authorized representative may be a county staff person for purposes of PCSP provider certification only.

To assist with transition, at county option, during the week of March 8, CDSS sent a cover letter (Attachment D) to IPs informing them about the need for them to complete the provider enrollment form and return it to the county promptly in order to avoid delays in payments. Alternatively, the county may choose to duplicate the camera-ready form attached and send it to providers with their own cover letter.

The contract agency will become the enrolled provider in the contract mode. If the county has a contract with a contract agency to provide IHSS, the contract agency has become an enrolled provider as soon as the county has a signed SOC 431 (Attachment F) in its possession. Since neither a consortium nor a public authority is the employer of service providers, except for the limited purposes declared in SB 485, neither is subject to provider enrollment.

If a PCSP-eligible recipient is served by both an enrolled provider and one who is not enrolled, the enrolled provider will be funded by PCSP funds and the unenrolled provider will be funded by non-PCSP funds.

An IP cannot be paid from PCSP funds if he/she is the recipient's spouse when the recipient is legally married or if he/she is the recipient's parent(s) (by birth or adoption) when the recipient is an unemancipated minor.

MAXIMUM

The non-PCSP program continues to have separate maxima for severely and nonseverely impaired recipients. However, PCSP will only have a single maximum of 283 hours per month. Any nonseverely impaired PCSP recipient who

is authorized 195 hours per month and who has a documented unmet need is entitled to an increase in authorization by the amount of the unmet need up to the maximum of 283 hours per month. Staff must identify the cases affected and increase the authorization.

Any nonseverely impaired PCSP recipient who is authorized protective supervision is entitled to an increase in the authorization to the maximum of 283 hours per month. Staff must identify the cases affected and increase the authorization.

Since the recipient whose hours are increased because of the single maximum in PCSP does not meet the statutory definition of severe impairment, he/she is not entitled to the option of advance payment. Special care must be given to assure that the hours of recipients whose authorizations increase in excess of the nonseverely impaired maximum be reduced to 195 hours per month if, for some reason, he/she becomes ineligible for PCSP funding, even temporarily.

NURSE SUPERVISION

PCSP funding is dependent upon nurse supervision of the care plan. This must be done by a Registered Nurse (RN). A Public Health Nurse (PHN) may provide nurse supervision, since all PHNs are RNs. Nurse supervision is defined in MPP Section 30-780.2(d) (Attachment A). The SOC 427 must be signed by the nurse at least every 12 months. A case is in compliance with nursing review of the service authorization if, during the first 12 months of PCSP funding, the nurse has reviewed the case record. When reviewing the case record, the nurse must review the physician's certification of medical necessity (SOC 425) to assure that services, as determined by social services staff on the assessment/authorization document (SOC 293) and other pertinent case documentation are consistent. The nurse must indicate whether the recipient is eligible or not eligible for PCSP services based on the review of these documents and record it on the nursing review form (SOC 427; Attachment G). The SOC 427 must be signed by the nurse at least every 12 months and be maintained in the recipient's case record.

In addition to the required nurse's review of the PCSP case records, county social service staff will have nurses available for home visits when requested to evaluate nursing issues. Nurses may advocate on behalf of a client to the recipient's doctor. Documentation of these nursing activities will also be recorded on SOC 427 (Attachment G).

AUDIT TRAIL

Federal auditors will be auditing PCSP cases periodically. They will be identifying costs associated with cases out of compliance. Sanctions resulting from any state or federal findings of non-compliance will be shared based on the claiming ratio. The following are some of the required documents which will be subject to review on such an audit:

1. Annual reassessment of need (SOC 293).
2. Annual physician certification of medical necessity (SOC 425).
3. Provider certification (SOC 426 or SOC 431) for every provider funded by PCSP before PCSP funding is claimed.
4. Annual nurse review (SOC 427).
5. Timesheet supporting hours paid.

TRAINING

CDSS will be conducting regional training sessions March 15-24 to discuss implementation issues and answer questions. The schedule of these training sessions is Attachment H.

FISCAL CLAIMING

Time study and claiming instructions for PCSP will be transmitted to counties in the County Fiscal Letters (CFL) for the June 1993 quarter. If you have any questions regarding time studying or fiscal claiming, please contact the Fiscal Policy and Procedures Bureau, at (916) 657-3440.

SPECIAL RECOGNITION

We are pleased to acknowledge the following CWDA representatives who worked hard to review proposed policies and advise state staff as to potential operational problems. This effort has made the timely implementation of these changes possible:

NAME	REPRESENTING
Alison Glassey	CWDA Subcommittee Chair
Marsena Buck	Stanislaus Co.
Ken Clark	Orange Co.
T. Michael Decker	San Bernardino Co.
Dianne Edwards	Orange Co.
Danna Fabella	Sonoma Co.
Barbara Fitzgerald	Ventura Co.
Kathy Gallagher	Santa Clara Co.
Mary Goblirsch	Monterey Co.
Jim Hunt	Sacramento Co.
John Michaelson	San Bernardino Co.
Mike Noda	Yuba Co.
Mary Paige	Yolo Co.
Scott Pettygrove	Stanislaus Co.
Barbara Riley	Placer Co.
Yolanda Rinaldo	Sonoma Co.
Onita Spake	Santa Clara Co.
Julia Takeda	Los Angeles Co.
Linda Watts	Solano Co.
Mindy Yamasaki	Sacramento Co.
Kathy Whilden	Monterey Co.
Frank Mecca	Executive Director, CWDA
Wendy Russell	CWDA

CONTACT PERSON

Any questions about this letter or PCSP implementation should be directed to Mr. Robert A. Barton at (916) 657-2143.

Fred Miller

FRED MILLER
Deputy Director
Adult Services Division

Attachments

Attachment A -- draft CDSS regulations
Attachment B -- letter to recipients
Attachment C -- SOC 425 form documenting medical necessity
Attachment D -- letter to IPs
Attachment E -- SOC 426 Provider enrollment form
Attachment F -- SOC 431 PCSP Contract Agency Certification form
Attachment G -- SOC 427 Nurse form
Attachment H -- Training Schedule

Amend Section 30-700 to read:

30-700 PROGRAM DEFINITION (Continued) 30-700

.2 The Personal Care Services Program (PCSP) provides personal care services to eligible Medi-Cal beneficiaries pursuant to Welfare and Institutions Code Section 14132.95 and Title 22, California Code of Regulations, Division 3 and is subject to all other provisions of Medi-Cal statutes and regulations. The program is operated pursuant to Division 30. PCSP-specific regulations are duplicated herein as handbook for easy reference.

.3 Individuals who qualify for both IHSS and PCSP funding shall be funded by PCSP.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Section 14132.95, Welfare and Institutions Code.

Amend Section 30-753 to read:

30-753 SPECIAL DEFINITIONS 30-753

(a) (1) (Continued)

(2) Administrative activities for PCSP are those activities necessary for the proper and efficient administration of the county PCSP. In addition to all activities listed in Section 30-753(a)(1) as administrative activities for IHSS except Section 30-753(a)(1)(G), the following activities are considered administrative in nature, subject to PCSP funding:

(A) Nursing supervision;

(B) Clerical staff directly supporting nursing supervision of PCSP cases;

(C) Physician certification of medical necessity when such certification is completed by a licensed health care professional who is a county employee;

(D) Provider enrollment certification.

(23) (Continued)

(b) (Continued)

(c) (1) County Plan means the annual plan submitted to the State Department of Social Services specifying ~~the method of IHSS delivery to meet program objectives/ conditions/ and fiscal limitations~~ how the county will provide IHSS and PCSP.

(d) (1) Designated county department means the department designated by the county board of supervisors to administer the IHSS program.

(12) (Continued)

(23) (Continued)

(e) through (k) (Continued)

(l) (1) (Continued)

(2) Licensed Health Care Professional means a person who is a physician/ ~~chiropractor/ podiatrist or dentist~~ as defined and authorized to practice in this state in accordance with the California Business and Professions Code. (Continued)

(m) Minor means any person under the age of eighteen who is not emancipated by marriage or other legal action.

(n) through (r) (Continued)

(s) (1) Severely Impaired Individual means a recipient with a total assessed need, as specified in Section 30-763.~~2~~5, for 20 hours or more per week of service in one or more of the following areas:

(A) Any ~~nonmedical~~ personal care service listed in Section 30-757.14. (Continued)

(4) Spouse means a member of a married couple or a person considered to be a member of a married couple for SSI/SSP purposes. For purposes of Section 30-756.11 for determining PCSP eligibility, spouse means legally married under the laws of the state of the couple's permanent home at the time they lived together. (Continued)

(7) State-mandated program cost means those county costs incurred for the provision of IHSS to recipients, as specified in Section 30-757~~.1 et seq.~~, in compliance with a state approved county plan. Costs caused by factors beyond county control such as caseload growth and increased hours of service based on individually assessed need, shall also be considered state-mandated. (Continued)

Authority cited: Sections 10553, 10554, and 12301.1, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Sections 10554, 12300(c), 12301, 12304, 12306, 12308, ~~and~~ 13302, 14132.95, 14132.95(e), and 14132.95(f), Welfare and Institutions Code.

Amend Section 30-755 title to read:

30-755 PERSONS SERVED BY THE NON-PCSP IHSS PROGRAM 30-755

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Section 14132.95, Welfare and Institutions Code.

Adopt new Section 30-756 to read:

30-756 NEED

.1 Staff of the designated county department shall determine the recipient's level of ability and dependence upon verbal or physical assistance by another for each of the functions listed in Section 30-756.2. This assessment shall evaluate the effect of the recipient's physical, cognitive and emotional impairment on functioning. Staff shall quantify the recipient's level of functioning using the following hierarchical five-point scale:

.11 Rank 1: Independent: able to perform function without human assistance, although the recipient may have difficulty in performing the function, but the completion of the function, with or without a device or mobility aid, poses no substantial risk to his or her safety. A recipient who ranks a "1" in any function shall not be authorized the correlated service activity.

.12 Rank 2: Able to perform a function, but needs verbal assistance, such as reminding, guidance, or encouragement.

.13 Rank 3: Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.

.14 Rank 4: Can perform a function but only with substantial human assistance.

.15 Rank 5: Cannot perform the function, with or without human assistance.

.2 Staff of the designated county department shall rank the recipient's functioning in each of the following functions.

(a) Housework;

(b) Laundry;

(c) Shopping and errands;

(d) Meal preparation and cleanup;

(e) Mobility inside;

(f) Bathing and grooming;

(g) Dressing;

(h) Bowel, bladder and menstrual;

(i) Repositioning;

(j) Eating;

(k) Respiration;

(l) Memory;

(m) Orientation; and

(n) Judgment.

.3 Staff of the designated county department shall use the following criteria to support the determination of functional impairment:

.31 The recipient's diagnosis may provide information to substantiate demonstrated functional impairments, but the recipient's functioning is an evaluation of the recipient's capacity to perform self-care and daily chores.

.32 Need may be distinct from current practice. The assessment of need shall identify the recipient's capacity to perform functions safely. The assessment of need shall identify the recipient's capacity rather than level of dependence.

.33 The recipient's needs shall be assessed within his/her environment, considering the mechanical aids or durable medical appliances the recipient uses.

.34 The scales are hierarchical. The higher the score, the more dependent the recipient is upon another person to perform IHSS services activities.

.35 Most functions are evaluated on a five-point scale. However, the functions of memory, orientation and judgment contain only three ranks. The function of respiration contains only ranks 1 and 5. These inconsistencies in the ranking patterns exist because differing functional ability in these areas does not result in significantly different need for human assistance.

.36 The order in which the physical functions are listed in Sections 30-756.2(a) through (n) is hierarchical.

HANDBOOK BEGINS HERE

.361 In 95 percent of any impaired population, people tend to lose functioning in the inverse order of normal infant development. Therefore, it would be unlikely for a recipient to score higher ranks in the functions listed at the bottom of the list than those at the top. This listing should assist in the assessment process.

HANDBOOK ENDS HERE

.37 Mental functioning shall be evaluated as follows:

.371 The extent to which the recipient's cognitive and emotional impairment (if any) impacts his/her functioning in the 11 physical functions listed in Sections 30-756.2(a) through (n) is ranked in each of those functions. The level and type of human intervention needed shall be reflected in the rank for each function.

.372 The recipient's mental function shall be evaluated on a three-point scale (Ranks 1, 2, and 5) in the functions of memory, orientation and judgment. This scale is used to determine the need for protective supervision.

.4 Notwithstanding Section 30-756.11, staff shall rank a recipient the rank of "1" if the recipient's needs for a particular function are met entirely with paramedical services as described in Section 30-757.19 in lieu of the correlated task.

.41 If all of the recipient's ingestion of nutrients occurs with tube feeding, the recipient shall be ranked "1" in both meal preparation and eating because tube feeding is a paramedical service.

.42 If all the recipient's needs for human assistance in respiration are met with the paramedical services of tracheostomy care and suctioning, the recipient should be ranked a "1" because this care is paramedical service rather than respiration.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Section 12309, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

Amend Section 30-757 to read:

DRAFT

30-757 PROGRAM CONTENT 30-757

.1 Only those services specified below shall be authorized through IHSS. (Continued)

.14 ~~Nonmedical~~ pPersonal care services, limited to: (Continued)

(c) Consumption of food and assurance of adequate fluid intake consisting of feeding or related assistance to recipients who cannot feed themselves or who require assistance with special devices in order to feed themselves or to drink adequate liquids. (Continued)

(g) Rubbing of skin to promote circulation, turning in bed and other types of repositioning, assistance on and off seats and wheelchairs, or into and out of vehicles/, and range of motion exercises which shall be limited to the following:

(1) General supervision of exercises which have been taught to the recipient by a licensed therapist or other health care professional to restore mobility restricted because of injury, disuse or disease.

(2) Maintenance therapy when the specialized knowledge and judgment of a qualified therapist is not required and the exercises are consistent with the patient's capacity and tolerance.

(A) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(h) (Continued)

(i) Care of and assistance with prosthetic devices and assistance with self-administration of medications.

(1) Assistance with self-administration of medications consists of reminding the recipient to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets. (Continued)

.19 Paramedical services, under the following conditions:

.191 The services shall have the following characteristics: (Continued)

(c) are activities which include the administration of medications, puncturing the skin, or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional. (Continued)

.197 The authority of the licensed health care professional to order paramedical services and to indicate the time required to perform such services shall not be construed to grant authority to order or to assess the need for other services as specified in /11 through /18 above/

.1987 (Continued)

.1988 (Continued)

Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Peremptory Writ of Mandate, Disabled Rights Union v. Woods, Superior Court, Los Angeles County, Case #C 380047/; and Sections 12300, 12300(c)(7), and 12300.1, Welfare and Institutions Code.

Amend Section 30-758.21 to read:

.2 Counties shall have the authority to develop and use time per task and frequency guidelines for other services, except:

.21 ~~nonmedical~~ personal care services, Section 30-757.14. (Continued)

Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Peremptory Writ of Mandate, Disabled Rights Union v. Woods, Superior Court, Los Angeles County, Case #C 380047; and Section 12300, Welfare and Institutions Code.

Amend Sections 30-759.3, .4, and .7 to read:

.3 Pending final determination, a person may be considered blind or disabled for purposes of non-PCSP IHSS eligibility under the following conditions: (Continued)

.4 In-Home Supportive Services payment shall be made for authorizable services, as specified in Section 30-761.28, received on or after the date of application or of the request for services as provided in Section 30-009.224, if either the recipient or the provider does not qualify for PCSP. If the ineligible recipient/provider becomes eligible for payment under PCSP, payment shall be made from PCSP as soon as administratively feasible in lieu of IHSS. (Continued)

.7 A written notice of action containing information on the disposition of the request for service shall be sent to the applicant in accordance with MPP Sections 10-116 and 30-763.~~3~~8.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Section 14132.95, Welfare and Institutions Code.

Amend Sections 30-761.11, .13, .23, and .3 to read:

30-761 NEEDS ASSESSMENT STANDARDS 30-761

.1 Services shall be authorized only in cases which meet the following condition:

.11 The recipient is eligible as specified in Sections 30-755 or 30-780, except that services may be authorized on an interim basis as provided in Section 30-759.3. (Continued)

.13 Social services staff of the designated county department has had a face-to-face contact with the recipient in the recipient's home at least once within the past 12 months, and has determined that the recipient would not be able to remain safely in his/her own home without IHSS. If the face-to-face contact is due but the recipient is absent from the state but still eligible to receive IHSS pursuant to the requirements stated in Section 30-770.4, Residency, the face-to-face requirement is suspended until such time as the recipient returns to the state. (Continued)

.2 Needs Assessments (Continued)

.23 The designated county department shall not delegate the responsibility to do needs assessments to any other agency or organization. (Continued)

.3 IHSS staff shall be staff of a designated county department.

.31 Classification of IHSS assessment workers shall be at the discretion of the county.

.32 IHSS assessment workers shall be trained in the uniformity assessment system.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Section 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

Amend Section 30-763 to read:

30-763 ~~NEEDS ASSESSMENT PROCESS~~ SERVICE AUTHORIZATION 30-763

~~(1 The needs assessment process consists of four steps:~~

~~(11 determination of the total need for IHSS services;~~

~~.12 identification of available alternative resources;~~

~~.13 determination of services which shall be purchased by IHSS; and~~

~~(14 notification of recipient;~~

~~(2 Determination of the total need for IHSS services:~~

.21 Services staff shall ~~review the list of services available through IHSS as specified in Section 30-757 and as modified by the county plan specified in Section 30-766(1) and shall eliminate from consideration as needs those services which the recipient can perform, consistent with Section 30-761(14) and those other services which are clearly not needed or are inappropriate;~~ determine the need for only those tasks in which the recipient has functional impairments. In the functions specified in Section 30-756.2, a functional impairment shall be a rank of at least 2.

.211 (Continued)

~~(a)~~ .111 (Continued)

~~(b)~~ .112 (Continued)

~~(c)~~ .113 (Continued)

~~(d)~~ .114 (Continued)

.212 Applicant/recipient failure to cooperate as required in ~~(211(a) and (b) above~~ Section 30-763.11 shall result in denial or termination of IHSS ~~services~~.

.22 Using the needs assessment form, services staff shall calculate the number of hours per week needed for each of the services ~~not eliminated~~ determined to be needed by the procedure described in Section 30-763.21 ~~above~~.

.23 Shared Living Arrangements: The following steps apply to assessing need for clients who live with another person(s). With certain exceptions specified in Section 30-763.24 ~~below~~, the need for IHSS shall be determined in the following manner.

.231 (Continued)

(a) .311 (Continued)

(b) .312 (Continued)

(c) .313 (Continued)

(d) .314 (Continued)

.232 (Continued)

(a) .321 (Continued)

(b) .322 (Continued)

.233 (Continued)

(a) .331 (Continued)

(b) .332 (Continued)

.234 (Continued)

.235 Other IHSS Services:

(a) .351 The recipient's need for transportation services, paramedical services and nonmedical personal care services shall be assessed based on the recipient's individual need.

(b) .352 (Continued)

(1a) (Continued)

(2b) (Continued)

(3c) (Continued)

.24 (Continued)

.241 (Continued)

(a) .441 (Continued)

(b) .442 (Continued)

(c) .443 (Continued)

(1a) (Continued)

(2b) (Continued)

(3c) (Continued)

(4d) (Continued)

(5e) (Continued)

(d) .444 (Continued)

(1a) (Continued)

(2b) (Continued)

(3c) (Continued)

(e) .445 (Continued)

(1a) Personal care services

(2b) (Continued)

(f) .446 In addition to those services listed in (e) above Section 30-763.445, a spouse may be paid to provide the following services when he/she leaves full-time employment or wishes to seek employment but is prevented from doing so because no other suitable provider is available:

(1a) (Continued)

(2b) (Continued)

.242 (Continued)

(d) .421 (Continued)

(b) .422 (Continued)

.243 (Continued)

.244 (Continued)

(d) .441 (Continued)

(b) .442 (Continued)

(c) .443 (Continued)

(d) .444 (Continued)

.245 (Continued)

(a) .451 (Continued)

(1a) (Continued)

(2b) (Continued)

(3c) (Continued)

(b) .452 For the purposes of (a)(2) above Section 30-763.451(b), a suitable provider is any person, other than the recipient's parent(s), who is willing, available, and qualified to provide the needed IHSS.

(c) .453 (Continued)

(1a) The conditions specified in (a)(1) through (3) above Sections 30-763.451(a) through (c) shall be met.

(2b) The nonprovider parent shall be unable to provide the services because he/she is absent because of employment or in order to secure education as specified in 22(a) above Section 30-763.441, or is physically or mentally unable to provide the services, as specified in 22(b) above Section 30-763.442.

(3c) (Continued)

(d) .454 (Continued)

(1a) (Continued)

(2b) Medically related Personal care services, as specified in Section 30-757.14.

(3c) (Continued)

(4d) (Continued)

(5e) (Continued)

.246 (Continued)

(a) .461 (Continued)

(b) .462 (Continued)

.247 (Continued)

(a) .471 Domestic and heavy cleaning services shall not be provided in areas used solely by the provider. The need for related services may be prorated between the provider and the recipient, if the provider and the recipient agree. All other services shall be assessed based on the recipient's individual need, except as provided in Sections 30-763.233 and .234 above.

/23 Having determined the services needed and the total number of hours required to perform these services social service staff shall determine the amount of the various services which the recipient can provide in partial satisfaction of his/her need/ consistent with Section 30-763.23/

.265 Having estimated the need according to Sections 30-763.21 and .22 above, and after making the adjustments identified in /23/ /24/ and /25 above Sections 30-763.3 and .4 as appropriate, the remaining list of services and hours per service is the total need for IHSS services.

.36 (Continued)

.361 (Continued)

.3611 Social services staff shall arrange for the delivery of such alternative resources as necessary in lieu of IHSS program-funded services when they are available and result in no cost to the IHSS program or the recipient except as provided in subsection /3133(b) below Section 30-763.613.

.3612 The IHSS program shall not deliver services which have been made available to the recipient through such alternative resources, except as provided in /313 below Section 30-763.613.

.3613 (Continued)

.362 (Continued)

.3621 Social services staff shall obtain from the recipient a signed statement authorizing discussion of the case with any persons specified in /32 Section 30-763.62.

.3622 (Continued)

.363 (Continued)

.47 (Continued)

.471 (Continued)

.472 (Continued)

.58 (Continued)

.581 (Continued)

.5811 (Continued)

.5812 (Continued)

.5813 (Continued)

.Ø9 (Continued)

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.Ø91 (Continued)

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.Ø92 (Continued)

.Ø921 (Continued)

.Ø922 (Continued)

.Ø93 (Continued)

.Ø931 (Continued)

.Ø932 (Continued)

.Ø94 (Continued)

.Ø941 (Continued)

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.Ø942 (Continued)

.Ø943 For those recipients with an Individual Provider, the listing in Section 30-763.Ø941 ~~ÆÞØ¥¢~~ will be generated through use of a special reason code indicating increased hours due to the Miller vs. Woods court decision.

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Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Sections 12300, 12309, and 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

Amend Sections 30-765.1 and .2 to read:

30-765 COST LIMITATIONS 30-765

.1 The following limitations shall apply to all payments made for in-home supportive services:

.11 The maximum services authorized per month except as provided in Section 30-765.3, under IHSS to any recipient determined to be severely impaired, as defined in Section 30-753 ~~(ee)~~ (s)(1) shall be that specified in Welfare and Institutions Code Section 12303.4(b) or as otherwise provided by law. (Continued)

.12 The maximum services authorized per month except as provided in Section 30-765.3, under ~~IHSS~~ non-PCSP to any recipient determined not to be severely impaired shall be that specified in Welfare and Institutions Code Section 12303.4(a) or as otherwise provided by law. (Continued)

.13 The statutory maximum service hours per month shall be inclusive of any payment by IHSS for a restaurant meal allowance established in accordance with the Welfare and Institutions Code Section 12303.7. (Continued)

.14 The county shall not make monthly payments of IHSS monies to recipients in excess of the computed maximums in Sections 30-765.11, .12 and .13. The sum of the IHSS monthly payment and the recipient's share of cost, if any, shall not exceed the appropriate maximum.

.2 The statewide wage rate for individual providers shall be determined by the Department. Effective July 8, 1988, the statewide wage rate is $4.25.

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.21 ARTICLE 7 - PAYMENT FOR SERVICES AND SUPPLIES, Section 51535.2, Reimbursement Rates for Personal Care Services Program

(a) For the individual provider mode for providing personal care services, the reimbursement rate shall be a maximum of $5.50 per hour of service: provided, however, that the reimbursement rate in each county shall not exceed the rate in each county for the individual provider mode of service in the IHSS program pursuant to Article 7 (commencing with Section 12300) of Part 3 of Division 9 of the Welfare and Institutions Code, as it existed on September 28, 1992.

(b) For the contract mode for providing personal care services pursuant to Welfare and Institutions Code Sections 12302 and 12302.1, the reimbursement rates shall be those specified in the contract between the county and the agency contractor not to exceed the following maximum rates for services provided through State fiscal year 1993-1994 as follows:

(1)	Butte	$ 9.67
(2)	Nevada	$10.34
(3)	Riverside	$12.29
(4)	San Diego	$10.49
(5)	San Francisco	$13.39
(6)	San Joaquin	$10.86
(7)	San Mateo	$12.65
(8)	Santa Barbara	$11.76
(9)	Santa Clara	$13.54
(10)	Santa Cruz	$13.61
(11)	Stanislaus	$10.51
(12)	Tehama	$11.29
(13)	Ventura	$11.04

(c) Nothing in this section is intended to be a limitation on the rights of providers and beneficiaries or on the duties of the Department of Social Services, pursuant to Welfare and Institutions Code Section 12302.2 subdivision (a). Contributions, premiums and taxes paid pursuant to Welfare and Institutions Code Section 12302.2 subdivision (a) shall be in addition to the hourly rates specified in subdivision (a) of this section.

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Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Section 14132.95, Welfare and Institutions Code.

Amend Section 30-766 to read:

30-766 ~~PROGRAM CONTROLS~~ COUNTY PLANS 30-766

.1 (Continued)

.11 The plan shall be submitted to SDSS and shall be based upon relevant information, as specified in Welfare and Institutions Code Sections 12301 and 14132.95, including, but not limited to the information specified below:

.111 Projected caseload, hours paid, and costs per month/quarter by mode/;

.112 Modes of IHSS and PCSP service delivery the county intends to use;

.113 Estimated program costs for both the IHSS and PCSP programs;

.114 Methods the county will utilize to control non-PCSP program costs to comply with required fiscal limitations; and

.115 Program design intended to meet PCSP requirements.

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/112 Section 12301 of the Welfare and Institutions Code states/

The county shall also report which methods of outreach are being utilized by the county regarding the availability of services under this article/

HANDBOOK ENDS HERE

.12 (Continued)

.13 SDSS shall review each county plan for compliance with Welfare and Institutions Code Sections 12300, et seq. and 14132.95, *departmental* regulations of SDSS and DHS, and when appropriate, issue departmental approval. (Continued)

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; Chapter 939, Statutes of 1992.

Reference: Sections 10102, 12301, 12302, 12306, 12308, 13002, and 14132.95, Welfare and Institutions Code/; and Chapter 93, Statutes of 1989 (Budget Act of 1989).

Amend Section 30-767 to read:

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.3 Personal Care Services Program Providers

DHS regulation Section 51181 reads:

Personal Care Services Provider.

A personal care services provider is that individual, county employee, or county contracted agency authorized by the Department of Health Services to provide personal care services to eligible beneficiaries. An individual provider shall not be a family member, which for purposes of this section means the parent of a minor child or a spouse.

.4 Personal Care Services Program Provider Enrollment

DHS regulation Section 51204 reads:

Personal Care Services Provider.

All providers of personal care services must be approved by Department of Health Services and shall sign the "Personal Care Services Program Provider/Enrollment Agreement" form [SOC 426 (1/93)] designated by the Department agreeing to comply with all applicable laws and regulations governing Medi-Cal and the providing of personal care service. Beneficiaries shall be given a choice of service providers.

(a) Individual providers will be selected by the beneficiary, by the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian. The beneficiary or the beneficiary's personal representative, or in the case of a minor, the legal parent or guardian shall certify on the provider enrollment document that the provider, in the opinion of the beneficiary, is qualified to provide personal care so long as the person signing is not the provider.

(b) Contract agency personal care providers shall be selected in accordance with Welfare and Institutions Code Section 12302.1. The contract agency shall certify to the designated county department that the workers it employs are qualified to provide the personal care services authorized.

.5 Provider Audit Appeals

DHS regulation Section 51015.2 reads:

Providers of Personal Care Services Grievance and Complaints.

Notwithstanding Section 51015, when a provider of personal care services has a grievance or complaint concerning the processing or payment of money for services rendered, the following procedures must be met:

(a) The provider shall initiate an appeal, by submitting a grievance or complaint in writing, within 90 days of the action precipitating the grievance or complaint, to the designated county department identifying the claims involved and specifically describing the disputed action or inaction regarding such claims.

(b) The designated county department shall acknowledge the written grievance or complaint within 15 days of its receipt.

(c) The designated county department shall review the merits of the grievance or complaint and send a written decision of its conclusion and reasons to the provider within 30 days of the acknowledgement of the receipt of the grievance or complaint.

(d) After following this procedure, a provider who is not satisfied with the decision by the designated county department may seek appropriate judicial remedies in compliance with Section 14104.5 of the Welfare and Institutions Code, no later than one year after receiving notice of the decision.

HANDBOOK ENDS HERE

Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Sections 12302 and 14132.95, Welfare and Institutions Code.

Amend Section 30-768 to read:

30-768 OVERPAYMENTS/UNDERPAYMENTS 30-768

.1 Definition of Overpayment for Non PCSP Payments (Continued)

.2 Amount of Overpayment for Non PCSP Payments (Continued)

.3 Recovery of Overpayments for Non PCSP Payments (Continued)

.4 Definition of Underpayment for Non-PCSP Payments (Continued)

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.5 DHS regulation Section 50781 reads:

Potential Overpayments

(a) A potential overpayment occurs when any of the following conditions exist, as limited by (c).

(1) A beneficiary has property in excess of the property limits for an entire calendar month.

(2) A beneficiary or the person acting on the beneficiary's behalf willfully fails to report facts and those facts, when considered in conjunction with the other information available on the beneficiary's circumstances, would result in ineligibility or an increased share of cost.

(3) A beneficiary has other health coverage of a type designated by the Department [of Health Services] as not subject to post-service reimbursement, and the beneficiary or the person acting on the beneficiary's behalf willfully fails to report such coverage.

(b) A beneficiary of the person acting on the beneficiary's behalf willfully fails to report facts if he/she has completed and signed a Medi-Cal Responsibilities Checklist, form MC 217, and a Statement of Facts and has, within his/her competence, done any of the following:

(1) Provided incorrect oral or written information.

(2) Failed to provide information which would affect the eligibility or share of cost determination.

(3) Failed to report changes in circumstances which would affect eligibility or share of cost within 10 days of the change.

(c) If a change occurred in a person's circumstances and that change could not have been reflected in the person's eligibility determination for the month in which the change occurred or the month following because of the 10 day notice requirements specified in Section 50179, no potential overpayment exists in that month or in the following month if appropriate.

.6 DHS regulation Section 50786 reads:

Action on Overpayment -- Department of Health Services or County Unit Contracted to Collect Overpayments

(a) Upon receipt of a potential overpayment referral, the Department's Recovery Section or the county unit contracted to collect overpayments shall:

(1) Determine the amount of Medi-Cal benefits received by the beneficiary for the period in which there was a potential overpayment.

(2) Compute the actual overpayment in accordance with the following:

(A) When the potential overpayment was due to excess property, the actual overpayment shall be the lesser of the:

1. Actual cost of services paid by the Department during that period of consecutive months in which there was excess property throughout each month.

2. Amount of property in excess of the property limit during that period of consecutive months in which there was excess property throughout each month. This excess amount shall be determined as follows:

a. Compute the excess property at the lowest point in the month for each month.

b. The highest amount determined in a. shall be the amount of the excess property for the entire period of consecutive months.

(B) When the potential overpayment was due to increased share of cost, the actual overpayment shall be the lesser of the:

1. Actual cost of services received in the share of cost period which were paid by the Department.

2. Amount of the increased share of cost for the share of cost period(s).

(C) When the overpayment was due to excess property and increased share of cost, the actual overpayment shall be a combination of (A) and (B).

(D) When the potential overpayment was due to other factors which result in ineligibility the overpayment shall be the actual cost of services paid by the Department.

(E) Potential overpayments, due to beneficiary possession of other health coverage that is not subject to post-service reimbursement, shall be processed by the Department to determine and recover actual overpayments in all cases. The actual overpayment in such cases shall be the actual cost of services paid by the Department which would have been covered by a private health insurance or other health coverage, had the coverage been known to the Department. The actual overpayment shall not include any costs which can be recovered directly by the Department from the health insurance carrier or other source.

(3) Refer those cases where there appears there may be fraud to the Investigations Branch of the Department.

(4) Take appropriate action to collect overpayments in accordance with Section 50787.

.7 DHS regulation Section 50787 reads:

Demand for repayment

(a) The Department or the county unit contracted to collect overpayments shall demand repayment or actual overpayments in accordance with procedures established by the Department.

(b) The Department or the county unit contracted to collect overpayments may take other collection actions as permitted under state law.

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Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Section 14132.95, Welfare and Institutions Code.

Amend Section 30-769 to read:

.3 The County Has The Sole Responsibility For Determining And Investigating Fraud And Forgery for Non-PCSP (Continued)

.4 PCSP Fraud or Forgery

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.41 DHS regulation Section 50782 reads:

Fraud occurs if an overpayment occurs and the beneficiary or the person acting on the beneficiary's behalf willfully failed to report facts as specified in Section 50781(b) with the intention of deceiving the Department, the county department or the Social Security Administration for the purpose of obtaining Medi-Cal benefits to which the beneficiary was not entitled.

.42 If PCSP fraud or forgery occurs, DHS will follow the procedures cited in DHS regulation Section 50793.

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Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Section 14132.95, Welfare and Institutions Code.

Adopt new Section 30-780 to read:

30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY 30-780

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.1 Scope of Services

DHS regulation Section 51183 reads:

Personal Care Services

Personal Care services include (a) personal care services and (b) ancillary services prescribed in accordance with a plan of treatment.

(a) Personal Care services include:

(1) Ambulation including walking or moving around (i.e. wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation does not include movement solely for the purpose of exercise.

(2) Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub, or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

(3) Dressing includes putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

(4) Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

(5) Repositioning, transfer, skin care, and range of motion exercises.

(a) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

(b) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

(6) Feeding, hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, manipulating food on place. Cleaning face and hands as necessary following meal.

(7) Assistance with self-administration of medications. Assistance with self-administration of medications consists of reminding the beneficiary to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

(8) Respiration limited to nonmedical services such as assistance with self-administration of oxygen, assistance in the use of a nebulizer, and cleaning oxygen equipment.

(9) Protective Supervision consisting of observing beneficiary behavior in order to safeguard the beneficiary against injury, hazard, or accident. This service is available for monitoring behavior of non-selfdirecting, confused, mentally impaired, or mentally ill persons, whose physical functioning is such that they are able to and do put themselves at risk if not supervised. The following exceptions apply:

(A) Protective supervision does not include friendly visiting or other social activities.

(B) Protective supervision is not available when the need is caused by a medical condition and the form of supervision required is medical.

(C) Protective supervision is not available in anticipation of medical emergency.

(D) Protective supervision is not available to prevent or control anti-social or aggressive beneficiary behavior.

(E) Protective supervision is not an alternative to psychiatric commitment described in Welfare and Institutions Code Section 5150. Therefore, protective supervision is not available to prevent potential suicide or other self-destructive behavior.

(10) Paramedical services are defined in Welfare and Institutions Code Section 12300.1 as follows:

(A) Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgement based on training given by a licensed health care professional.

(B) Paramedical services are activities which persons would perform for themselves but for their functional limitations.

(C) Paramedical services are activities which, due to the beneficiary's physical or mental condition, are necessary to maintain the beneficiary's health.

(b) Ancillary services are subject to time per task guidelines established in Sections 30-758 and 30-763.235(b) and 30-763.24 of the Department of Social Services' Manual of Policies and Procedures and are limited to the following:

(1) Domestic services are limited to the following:

(A) Sweeping, vacuuming, washing and waxing of floor surfaces.

(B) Washing kitchen counters and sinks.

(C) Storing food and supplies.

(D) Taking out the garbage.

(E) Dusting and picking up.

(F) Cleaning oven and stove.

(G) Cleaning and defrosting refrigerator.

(H) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.

(I) Changing bed linen.

(J) Miscellaneous domestic services (e.g., changing light bulbs and wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the case worker as necessary for the beneficiary to remain safely in his/her home.

(2) Laundry services include washing and drying laundry, and is limited to sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry if dryer is not routinely used, mending, or ironing, folding, and storing clothing on shelves, in closets or in drawers.

(3) Reasonable food shopping and errands limited to the nearest available stores or other facilities consistent with the beneficiary's economy and needs. Compiling a list, bending, reaching, and lifting, managing cart or basket, identifying items needed, putting items away, phoning in and picking up prescriptions, and buying clothing.

(4) Meal preparation and cleanup including planning menus; washing, peeling and slicing vegetables; opening packages, cans and bags, mixing ingredients; lifting pots and pans; reheating food, cooking, and safely operating stove, setting the table and serving the meals; cutting the food into bite-size pieces; washing and drying dishes, and putting them away.

(5) Assistance by the provider is available for accompaniment when the beneficiary's presence is required at the destination and such assistance in necessary to accomplish the travel limited to:

(A) Accompaniment to and from appointments with physicians, dentists and other health practitioners. This accompaniment shall be authorized only after staff of the designated county department has determined that no other Medi-Cal service will provide transportation in the specific case.

(B) Accompaniment to the site where alternative resources provide in-home supportive services to the beneficiary in lieu of IHSS. This accompaniment shall be authorized only after staff of the designated county department have determined that neither accompaniment nor transportation is available by the program.

(6) Heavy Cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

(7) Yard hazard abatement which is light work in the yard which may be authorized for:

(A) removal of high grass or weeds and rubbish when this constitutes a fire hazard

(B) removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.

(c) Ancillary services may not be provided separately from personal care services listed in subsection (a) above.

.2 Personal Care Services Program Tasks

DHS regulation Section 51350 reads:

Personal Care Services.

(a) Personal care services as specified in Section 51183 are provided when authorized by the staff of a designated county department based on the state approved Uniformity Assessment tool. To the extent not inconsistent with statutes and regulations governing the Medi-Cal program, the needs assessment process shall be governed by the Department of Social Services' Manual of Policies and Procedures Sections 30-760, 30-761, and 30-763.

(b) Personal care services may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. This shall be established by staff of the designated county department by determining that the beneficiary ranks at least a "3" in one mental or personal care function using the state approved Uniformity Assessment tool. The services shall be provided in the beneficiary's home or other locations as may be authorized by the Director subject to federal approval. Personal care services authorized shall not exceed 283 hours in a calendar month.

(c) Personal care services must be prescribed by a physician. The beneficiary's medical necessity for personal care shall be certified by a licensed physician. Physician certification shall be done annually.

(d) Registered nurse supervision consists of review of the service plan and provision of supportive intervention. The nurse shall review each case record at least every twelve months. The nurse shall make home visits to evaluate the beneficiary's condition and the effectiveness of personal care services based on review of case record or whenever determined as necessary by staff of a designated county department. If appropriate, the nurse shall arrange for medical follow-up. All nurse supervision activities shall be documented and signed in the case record of the beneficiary.

(e) Paramedical services when included in the personal care plan of treatment must be ordered by a licensed health professional lawfully authorized by the State. The order shall include statement of informed consent saying that the beneficiary has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the beneficiary, the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian.

(f) Protective supervision is available for beneficiaries who have been assessed as confused, non-self directive, mentally impaired or mentally ill. Protective supervision is required in order to protect the beneficiary against injury, hazard or accident. The need for protective supervision is identified by the staff of a designated county department and is documented in the beneficiary's plan of care.

(g) Grooming shall exclude cutting with scissors or clipping toenails.

(h) Menstrual care is limited to external application of sanitary napkin and cleaning. Catheter insertion, ostomy irrigation and bowel program are not bowel or bladder care but paramedical.

(i) Repositioning, transfer, skin care, and range of motion exercises have the following limitations:

(1) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

(2) Range of motion exercises shall be limited to the general supervision of exercises which have been taught to the beneficiary by a licensed therapist or other health care professional to restore mobility restricted because of the injury, disuse or disease. Range of motion exercises shall be limited to maintenance therapy when the specialized knowledge or judgement of a qualified therapist is not required and the exercises are consistent with the beneficiary's capacity and tolerance. Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

.3 Personal Care Services Program Required Documentation

DHS regulation Section 51476.2 reads:

Personal Care Services Program Records.

Each county shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of personal care services provided to a Medi-Cal beneficiary. Records shall be made at or near the time the service is rendered or the assessment or other activity is performed. Such records shall include, but not be limited to the following:

(a) Timesheets

(b) Assessment forms and notes

(4) All service records, care plans, and orders/prescriptions ordering personal care.

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.4 Eligibility for PCSP shall be limited to those IHSS recipients who do not receive IHSS advance payment as specified in Section 30-769.731.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992.

Reference: Section 14132.95, Welfare and Institutions Code; and the State Plan Amendment, approved pursuant to Section 14132.95(b), Welfare and Institutions Code.

IMPORTANT
Please read this letter.

Dear IHSS Client:

The In-Home Supportive Services Program (IHSS) will soon be making changes which will permit California to receive federal funds. This will enhance the quality of service for many of our clients. This program change will be called the Personal Care Program (PCP).

What Does This Change Mean to You?

When the PCP is implemented, the State will be able to restore to all IHSS clients the 12 percent reduction in service hours which occurred last Fall. The new PCP will not make any other changes to your IHSS benefits or services. You may continue to select your own provider.

We Need Your Assistance!

Enclosed is the Physician's Certification of Medical Necessity form. We need this form to verify that you require personal care services. Please complete the form following the instructions below and mail it as soon as possible to your doctor, and have your doctor return it to the County IHSS office (within 10 days).

Physician's Certification of Medical Necessity Form

1. Under the section labeled "Patient Authorization," please sign and date.

2. Mail the form to your doctor to complete the section labeled "For Physician's Use Only." (Note: If your doctor must examine you to prescribe personal care services, the doctor may bill Medicare or Medi-Cal for the examination.)

Provider Form

Your provider(s) will be receiving a separate PCP form called the Personal Care Program/Enrollment Agreement form. This form is used to enroll your provider(s) as a PCP Medi-Cal provider. Your provider will be asking you to complete Part II and to sign and date the form. (Note: Your provider, including a relative provider, cannot sign the form as your authorized representative.) Either you or your provider should return this Enrollment Agreement form to the County IHSS office.

If you have any questions, please contact the County IHSS office.

PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY

DATE:

This form must be completed to determine Personal Care Program eligibility and annually for recertification.

After completion, return this form to the agency address indicated below.

PATIENT'S NAME	DATE OF BIRTH	CASE NUMBER

Dear Doctor:

The Personal Care Program provides assistance through In-Home Supportive Services, to those eligible indivduals who are limited in their ability to care for themselves and would be unable to remain safely in their own homes without this service.

Your patient has requested help with one or more of the following personal care services: assistance with ambulation; bathing; oral hygiene; grooming; dressing; care and assistance with prosthetic devices; protective supervision; bowel, bladder and menstrual care; repositioning, skin care, range of motion exercises and transfers; feeding and assurance of adequate fluid intake; respiration; or assistance with self-administration of medications.

Your examination of this patient may be reimbursable through Medi-Cal as an office visit provided that all other applicable Medi-Cal requirements are met, or through Medi-Care.

AGENCY	SERVICE WORKER	SERVICE WORKER NUMBER

AGENCY ADDRESS (Street, City, Zip)	PHONE ( )

SERVICE WORKER'S SIGNATURE	DATE

PATIENT AUTHORIZATION

By signing this form, I hereby authorize the release of information, including information regarding alcoholism, drug abuse, mental illness or HIV infection, pertaining to my medical neccessity for personal care services to the above named agency.

PATIENT'S SIGNATURE (Or Authorized Representative)	DATE

FOR PHYSICIAN'S USE ONLY

PHYSICIAN'S NAME	PHONE ( )

OFFICE ADDRESS (Street, City, Zip)

DIAGNOSIS	DATE LAST SEEN BY PHYSICIAN

PROGNOSIS (If Known)

I recommend one or more of the above listed personal care services for this patient in order to prevent out-of-home placement. ☐ Yes ☐ No

PHYSICIAN'S SIGNTURE	PROVIDER NUMBER	DATE

IMPORTANT
Please read carefully to make sure that you are paid correctly.

Dear IHSS Provider:

This is to inform you about the new IHSS Personal Care Program (PCP) which will soon be implemented Statewide.

Under PCP, personal care services currently paid through In-Home Supportive Services (IHSS) will be paid by the Medi-Cal Program. Services such as assistance with bathing, grooming, dressing, bowel and bladder care, and feeding are considered personal care services under PCP.

What Does This Change Mean to You?

When PCP is implemented, the State will also restore the 12 percent reductions in service hours to all IHSS recipients Statewide. Providers of service to their own minor children or to their own spouses do not have to complete this form.

We Need Your Assistance in Order for You to be Paid Correctly!

Enclosed is a Personal Care Program Provider/Enrollment Agreement form. We need this form to enroll you and the IHSS recipient under the PCP Program. Please complete the form following the instructions below and mail it immediately (within 5 days) to the County IHSS office shown at the top of the form.

Personal Care Program Provider/Enrollment Agreement Form

1. Read the certification statement in Part I.

2. In Part I, sign and date the form.

3. Give the form to the IHSS recipient. In Part II, the recipient must print his/her name and case number. The recipient or his/her authorized representative must sign and date the form. (Note: You cannot sign this form as the authorized representative if you are a relative provider.)

4. Send the form to the County IHSS Office.

If you have any questions, please contact the County IHSS office.

PERSONAL CARE PROGRAM
PROVIDER/ENROLLMENT AGREEMENT

Instructions:

- *This form is to be completed in triplicate.*
- *This form must be completed prior to enrollment for **each** service provider/client relationship.*
- *Part I is to be completed by the service provider.*
- *Part II is to be completed by the client or authorized representative as long as the authorized representative is **NOT the service provider.***
- *Part III is to be completed by the county.*
- *The original form is to be maintained by the county and a copy given to the provider and the recipient.*

PART I - SERVICE PROVIDER

SERVICE PROVIDER NAME	SOCIAL SECURITY NUMBER
ADDRESS (Street, City, Zip)	PHONE ( )

CERTIFICATION STATEMENT

- I certify that all claims, which I submit, for services to clients of the Personal Care Program, provided through the In-Home Supportive Services Program, will be provided as authorized for the client.
- I certify that all information submitted to the county will be accurate and complete to the best of my knowledge.
- I understand that payment of these claims will be from federal and/or state funds and that any false statement, claim, or concealment of information may be prosecuted under federal and/or state laws.
- I agree that services will be offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

SERVICE PROVIDER'S SIGNATURE	DATE

PART II - CLIENT CERTIFICATION

I certify that the service provider named above is qualified to provide personal care services for me as authorized by the county.

CLIENT'S NAME	CASE NUMBER
CLIENT'S SIGNATURE (Or Authorized Representative)	DATE

PART III - RECORD RETENTION

On behalf of the service provider, the county shall keep all records which are necessary to fully disclose the extent of services to the client for a minimum of three years from the date of service; and on request shall furnish the records for audit to the State of California or the U.S. Department of Health and Human Services or their duly authorized representatives.

AUTHORIZED COUNTY REPRESENTATIVE'S SIGNATURE	SERVICE WORKER NUMBER	DATE

PART IV- HEALTH SERVICES APPROVAL

I certify that the person named above will be an enrolled Medi-Cal provider of personal care services.

Albert Seltzer

Albert Seltzer, Department of Health Services

PERSONAL CARE PROGRAM
CONTRACT AGENCY ENROLLMENT

Instructions:

- *This form is to be completed in duplicate.*
- *This form must be completed for each contract and prior to enrollment by each public or private agency contracted to provide Personal Care Program services.*
- *Part I is to be completed by the authorized representative of the contract agency.*
- *Part II is to be completed by the County.*
- *The original form is to be maintained by the County and a copy given to the contract agency.*

PART I - CONTRACT AGENCY

CONTRACT AGENCY NAME	STATE CONTRACT NUMBER
ADDRESS (Street, City, Zip)	PHONE ( )

CERTIFICATION STATEMENT

- I certify that all employees of this agency are qualified to provide the care authorized.
- I certify that all claims submitted to the County for services to recipients of the Personal Care Program and provided by this agency, will be provided as authorized for the recipient.
- I understand that payment of these claims will be from federal and/or state funds and that any false statement, claim, or concealment of information may be prosecuted under federal and/or state laws.
- I agree that services will be offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

SIGNATURE AND TITLE OF AUTHORIZED REPRESENTATIVE	DATE

PART II - RECORD RETENTION

The County shall ensure that during the effective dates of this contract, the contract agency shall keep all records which are necessary to fully disclose the extent of services to the client for a minimum of three years from the date of service. At the expiration of this contract, County shall keep said records for a minimum of three years from the date of service. On request, the County shall furnish records for audit to the State of California or the U.S. Department of Health and Human Services or their duly appointed representatives.

SIGNATURE AND TITLE OF AUTHORIZED COUNTY REPRESENTATIVE	COUNTY	DATE

PART III- HEALTH SERVICES APPROVAL

I certify that the agency named above will be an enrolled Medi-Cal provider of personal care services.

Albert Seltzer, Department of Health Services

PERSONAL CARE PROGRAM
NURSE REVIEW

RECIPIENT NAME	CASE NUMBER	SERVICE WORKER NUMBER

☐ ELIGIBLE ☐ NOT ELIGIBLE

Comments:

RN SIGNATURE	RN IDENTIFICATION NUMBER	DATE

☐ ELIGIBLE ☐ NOT ELIGIBLE

Comments:

RN SIGNATURE	RN IDENTIFICATION NUMBER	DATE

☐ ELIGIBLE ☐ NOT ELIGIBLE

Comments:

RN SIGNATURE	RN IDENTIFICATION NUMBER	DATE

☐ ELIGIBLE ☐ NOT ELIGIBLE

Comments:

RN SIGNATURE	RN IDENTIFICATION NUMBER	DATE

Attachment H

PCSP TRAINING*

Northern Region Yuba - Peach Tree Mall 6000 Lindhurst Avenue Marysville Contact: Mike Noda (916) 741-6364	March 15, 1993 9:30 A.M.
Valley Mountain Region Fresno - Manchester Mall Blackstone and Shields Contact: Mary Paige (916) 372-2000	March 16, 1993 10 A.M.
Central Region Marin - CTA Building 210 N. San Pedro Road Marin Contact: K.G. Dorosz (510) 374-3335	March 18, 1993 9:30 A.M.
Los Angeles Santa Fe Springs Training Center Rooms 111 A & B Contact: Gail Swensen (310) 908-8376	March 22, 1993 9 A.M.
Southern Region (except L.A.) Orange - County Library 1501 Saint Andrews Place Santa Ana Contact: Margaret Beck (714) 566-3108	March 24, 1993 10 A.M.

* Maps to these locations will be sent to the appropriate counties by the contact persons.